The Development of *Geographically-Based SGH Community Nursing* In SingHealth (Southeast) Regional Health System

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Introduction

Recognising the need for a paradigm shift in care for an ageing population, which brings about an increased prevalence of chronic conditions, it is an opportune for communtiy nurses to support the changing healthcare landscape and enhance upstream care for our residents in the community. The SingHealth South East (SE) Regional Health System (RHS) - led SGH community nursing service which is supported by the Ministry of Health (Singapore) came timely as one of the strategies to anchor population health and facilitate the shift beyond acute care to community care. Community nursing is envisaged as a key anchor for population health management and as such, the team is expected to respond to a portfolio of residents, and provide services including i) early interventions for pre-frail seniors, ii) chronic disease management for patients whose conditions are not well-controlled, iii) care for frails patients in their immediate post-discharge period, and iv) palliative care for end-of-life patients. These services are provided for residents living within the five SingHeath (SE) Communities of Care (CoC) zones, namely Bukit Merah, Chinatown, Katong, Telok Blangah and Tiong Bahru. To empower our population to keep well, get well and age well in their communtiies and homes, the geographically-based community nursing team collaborates with community partners across the health and social care sectors to establish the concept of health promotion and to delay or reduce hospital care. This approach allows deeper understanding of the population needs in respective zones, greater accessibility with good skill-mix for different levels of needs and care and increased efficiency in community resource allocation.

Figure 1: Community nursing scope of services

Community Nurse Post

The RHS-led SGH Community Nursing Programme was officially launched on 28 February 2018 with the establishment of the 1st Community Nurse Post (CNP). In line with SingHealth RHS's ongoing efforts to strengthen community care, these CNPs were progressively set-up within the five CoC to reach out to more residents. The aims of the CNP are to bridge the gap between care in the hospital and community and to complement the services provided by community service providers and primary care sector. Community-based nurses are ensconced in the CNPs at the senior activity and family service centres, religious organization, Residents' Committee, medical clinic in the neighbourhood. Figure 1 illustrates the scope of services provided at the CNPs.

The services at the CNPs target on pre-frail and frail seniors who require assistance to better manage their chronic diseases. The CNPs operate from half a day to daily during weekdays based on residents' needs and availability of facility spaces. In addition to running the CNPs, community nurses also conduct home visits for home-bound residents. Joint visits with community partners often take place for residents with complex issues. As of January 2019, there are twenty-four CNPs and a total of 3298 residents have benefitted from this programme.

Role of Community Nurse in Primary Care

Community Nursing Programmes often place great emphasis on empowering resident's self-management, which underlines its importance in primary care and the complex process of caring for residents with chronic conditions. Nurses are generally well versed in self-care support and play a leading role in conducting education which focuses on preserving or enhancing health and self-management in a holistic perspective. A systematic review of twenty-nine studies by Massimi et al., (2017) highlighted that community-based nurse-led interventions are effective when delivered by trained nurses to patients with diabetes or cardiovascular diseases for their self-management support.

The RHS-led SGH community nursing team is led by an Advanced Practice Nurse. Each team comprises of a Team Leader who is a nurse clinician, and four to six senior nurses. The interventions by community nurses can be delivered through face-to-face/telephone, at either the resident's home, nurse-led posts, local community activity centres or in primary care clinics. At the CNPs, the community nurses use simplified education guide to help senior residents understand their chronic diseases and treatment, including medication. They monitor residents' blood pressure and capillary blood glucose, empowering them on self-management and explaining investigation results. Short-term medication packing is provided for residents who have difficulties in managing their own medication. The follow-up duration at CNPs is based on individual's progress. The senior residents appreciate this combined effort as it builds up their confidence in managing their own chronic conditions and facilitates communication with their primary care team. Vice versa, the primary care teams also feel assured that they can work closely with the community nurses to manage residents' conditions on a long-term basis.

In addition to the services provided at the CNPs, community nurses also conduct outreach programmes on health promotion and disease prevention through individual and group health coaching. The Community Falls Prevention Programme (CFPP) forms part of these service initiatives based on the understanding that significant problems may arise after falls among seniors. The CFPP was implemented in April 2018 targeting at pre-frail seniors through an evidenced-based screening and cost-effective falls prevention interventions. Those identified with high fall risk will receive individualised health coaching and either be referred for community-based structured exercises, rehabilitation program or medical consults.

Challenges for Nurses Transiting to Community Services

The RHS-led SGH community nurses are all transitioned from an acute care sector. They have to leave behind the sense of security of knowing that they are part of a larger team in a highly regulated organisation. Nurses transitioning into the community are required to learn (i) time management including prioritizing goals, (ii) planning, delegation and communication, and (iii) personal professional accountability as they are expected to make independent decisions on a range of issues relating to resident education and support, clinical care and medication management (Ellis & Chater, 2012). The working partnership for community nurses also goes beyond the hospital multidisciplinary team. In the community, the concept of 'team' becomes broadened to include staff working for other social, health care, religious, government agencies and more. The training for community nurses also moves beyond the specialist role to a generalist on areas of health promotion, chronic disease management, geriatric care, mental health, palliative care etc.

Moving Forward

The RHS-led SGH community nursing model will continue to evolve, with refinement of work processes and enhancement and expansion of role, scope and services to support new RHS initiatives. Capability building on generalist community nursing role in palliative care and mental health is also in the training pipeline. To further improve care efficiency, the team is leveraging on technology such as telehealth i.e. Vital Signs Monitoring (VSM) to promote self-management of chronic diseases at CNPs; Video Consultation (VC) that allows provider-to-provider VC for residents with complex care under home care.

The community nursing team continues to collaborate with community partners to synergise services, i.e. working with religious group to outreach to Muslim community; combining community functional screening with CFPP. Strong partnership is also forged with primary care team i.e. SingHealth DOT GP programme, SingHealth Polyclinics on seamless referrals, co-managing of residents with chronic diseases and escalation of care.

Working together as part of the RHS family, the team will collaboratively identify value-added community nursing services and evaluate residents' outcomes, in tandem with the ultimate goals of greater access, quality and cost efficient healthcare.

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